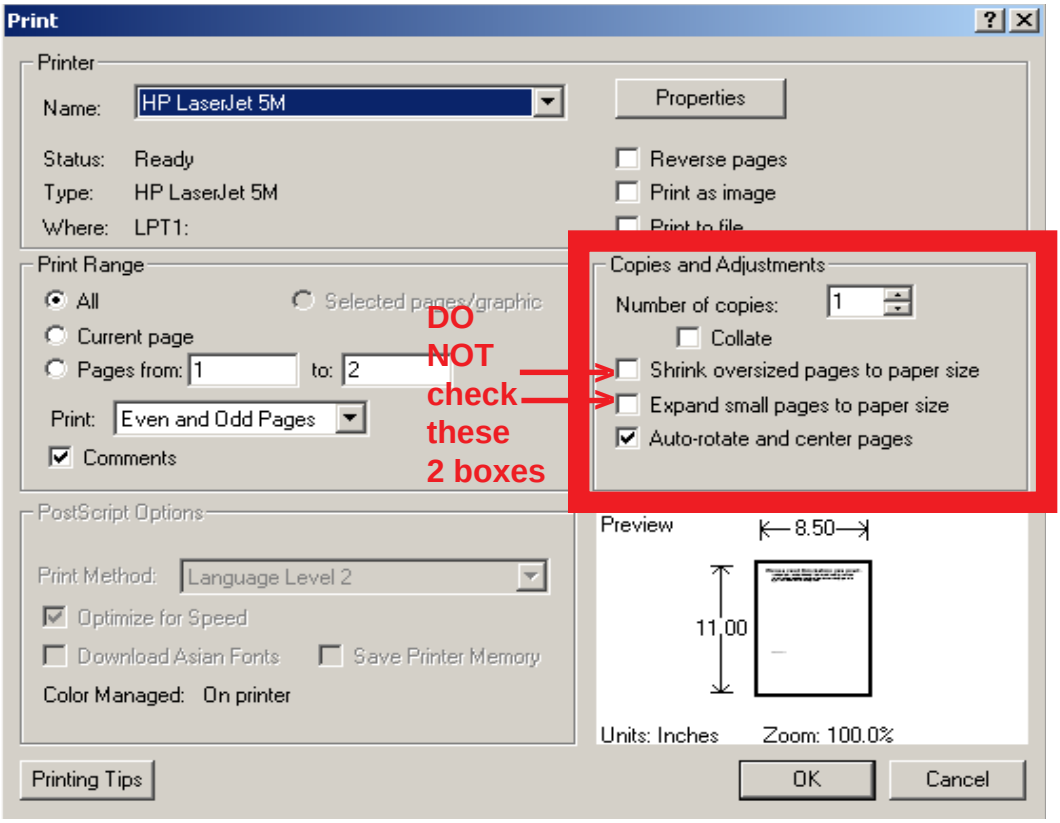
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

ARNP and ARNP with Prescriptive Authority Application Packet

1. 669-220 .. Contents List/SSN Information/Deposit Slip ..... 1 page
2. 669-209 .. Instructions—Application for ARNP and ARNP with Prescriptive Authority ..... 2 pages
3. 669-099 .. Application for ARNP and ARNP with Prescriptive Authority ..... 4 pages
4. 669-208 .. Sample Joint Practice Agreement for Prescribing Schedule II-IV Medications ..... 2 pages

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below. The back of the Deposit Slip **must** be blank.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

ARNP / ARNP with Prescriptive Authority

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 669-220 (REV 9/2003)

1F 0258040000 00499

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Washington State Department of Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

ARNP And ARNP With Prescriptive Authority

Please read WAC 246-840-300 through 450. Depending on your circumstances, different evidence is required by Washington State for your Nurse Practitioner license. If you have questions, you may call 360-236-4708.

- **A current/active RN license in Washington and National Certification is required** (WAC 246-840-300).
- A **Master's degree in Nursing** is required for those licensed after January 1, 1995 (WAC 246-840-305 (1)(e)(iii & iv)).
- Prescriptive Authority is available for those who meet requirements of WAC 246-840-350.
- An Interim Permit is available for those who meet requirements of WAC 246-840-350.

Application Instructions

1) Complete the application.
   - Personal Data Questions must be answered. Check each one 'yes' or 'no'. For those answered with a 'yes', please attach an explanation and any documents pertaining to this question.
   - Read the Applicant's Attestation.
2) Send a check or money order for $65 payable to Dept. of Health with your application.
3) Have or obtain a **current/active Washington RN license**.
4) Your official transcript(s) must come directly from the college or university where you completed your Master's degree in nursing and/or your advanced practice preparation. **They must be submitted to the Nursing Commission in a sealed envelope**.
   - A Minimum of one academic year is required for preparation for ARNP licensure. WAC 246-840-340 (5)(c).
   - If no Master's degree, provide evidence of ARNP (licensure recognition in another jurisdiction) prior to December 31, 1994 **and ARNP certification** prior to December 31, 1994.
5) If your transcript does not state that you completed an advanced registered nurse practitioner program, you will **need to request a letter from your dean or instructor documenting the area of specialty** practice you completed.
   - If your program was from a school outside Washington State, please submit program objectives and course descriptions.
6) If you completed the nurse practitioner program more than five (5) years ago, verification of 1500 hours of employment in the expanded specialty role within the past five years is required. And if you do not meet educational requirements, 500 hours of supervised clinical practice may be required (WAC 246-840-340 (3 & 6)).
7) **Current National Certification must come from Board.**
8) There are two levels of Prescriptive Authority for ARNPs in Washington State. For either or both levels of Prescriptive Authority, please submit documentation of 30 contact hours for the pharmacology/drug therapy course(s) taken within the past two (2) years.
   - If you are a newly graduated NP and the credits were part of your academic program, please indicate the course number/title on the application under Section 2 Education.
   - If you want prescriptive authority for Schedules II-IV, you must submit a Joint Practice Agreement (WAC 246-840-421 and 422), with your application. A sample Agreement is included with these instructions. You may have a Joint Practice Agreement with more than one physician.

9) When applying for an **Interim Permit**, we require all of the requested documentation for licensure and a copy of the **letter from the national certifying body** which indicates you are registered for taking the exam.

   - If an interim permit is issued, it is valid until you are licensed as an ARNP; you fail the exam; or, you fail to show for the exam (whichever occurs first).
   - The interim permit is not renewable.
   - Prescriptive Authority is not granted with an interim permit.
   - The National Certification Board must send a letter stating you are certified.

10) If you currently have prescriptive authority in Washington State and wish to apply for expanded prescriptive authority for the new Schedule II-IV, you will need to submit a completed application, the $65 application fee and a Joint Practice Agreement. WAC 246-840-421 and 422.

Return the completed application, $65 fee (payable to **Department of Health**), and other required materials to:

Washington Nursing Commission
PO Box 1099
Olympia WA 98507-1099

If you have questions, call 360-236-4708.

ARNP Designations That Are Recognized And Licensed By The State Of Washington

A Nurse Practitioner may practice independently in Washington. The scope of practice is established by and may be obtained from the National Certifying body (WAC 246-840-300).

The following National Certification programs are approved by the Nursing Commission for ARNP designation. The code next to each specialty is the authority code used in licensing. This code is printed on both the official and wallet copies of your license. When the code ends in 'zero', (e.g. 010), it designates Prescriptive Authority; if the code ends in 'one' (e.g. 011), it designates **without** Prescriptive Authority for the particular specialty.

American Association of Nurse Anesthetists (AANA) 847-692-7050
- 010 Nurse Anesthetist

American College of Nurse Midwives (ACNM) 301-459-1321
- 020 Nurse Midwife

American Nurses Credentialing Center (ANCC) 800-284-2378
- 050 Family Nurse Practitioner
- 030 Adult Nurse Practitioner
- 060 Gerontological Nurse Practitioner
- 140 School Nurse Practitioner
- 100 Clinical Specialist in Psych/Mental Health Nursing
- 090 Pediatric Nurse Practitioner
- 170 Acute Care Nurse Practitioner

National Certification Board of Pediatric Nurse Practitioners and Nurses (NBPNP/N) 301-340-8213
- 090 Pediatric Nurse Practitioner

National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties (NCC) 800-673-8499
- 120 Womens Health Care Nurse Practitioner
- 160 Neonatal Nurse Practitioner

American Academy of Nurse Practitioners (AANA) 512-442-4262
- 030 Adult Nurse Practitioner
- 050 Family Nurse Practitioner

Washington State Department of Health

Health Professions Quality Assurance Division
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE #

LICENSE #

Application For ARNP And Prescriptive Authority

Check all that apply:

☐ **Request ARNP** ☐ **Request Prescriptive Authority** ☐ **Request Interim Permit** ☐ **Request Schedules II-IV**

Fee must accompany application, includes Prescriptive Authority and is non-refundable. Make checks payable to Department of Health. There are 10 areas of Advance Practice that Washington State Licenses. Please check only one per application. **Note: each Advanced Practice requires an application and fee.**

☐ **Family Nurse**	☐ **Nurse Midwife**	☐ **Clinical Spec in Psych/Mental**	☐ **Nurse Anesthetist**
☐ **Pediatric Nurse**	☐ **Adult Nurse**	☐ **Geriatric Nurse**	☐ **Acute Care Nurse**
☐ **School Nurse**	☐ **Neonatal Nurse**	☐ **Woman's Health Care Nurse**	

1. Demographic Information

APPLICANT'S NAME — LAST — FIRST — MIDDLE NAME OR INITIAL

OTHER NAMES USED

RESIDENCE address

CITY	STATE	ZIP	COUNTY

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)	RESIDENCE TELEPHONE	SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)	DATE OF BIRTH (MO / DAY / YEAR)
( )	( )	— —	/ /

☐ Currently nationally certified as a nurse practitioner in the area of _____
SPECIALTY

by _____ on _____
NATIONAL CERTIFYING BODY — DATE OF RECOGNITION

☐ Not currently certified but have registered for a board approved national examination in the area of

_____ by _____
SPECIALTY — NATIONAL CERTIFYING BODY

on _____
EXAM DATE

2. Previous Licensure

List all states where any health care licenses are or were held. Specifically list licenses granted as temporary, reciprocity, exemption or similar with type, date, grantor, and if license is current.

STATE/JURISDICTION	PROFESSION	LICENSE TYPE	LICENSE		METHOD OF LICENSURE
			YEAR ISSUED	NUMBER	

3. Personal Data Questions

	YES	NO
1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

(If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the treatment ongoing, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain.	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism?	☐	☐
4. Are you currently engaged in the illegal use of controlled substances?	☐	☐

"Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

"Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:		
a. the use or distribution of controlled substances or legend drugs?	☐	☐
b. a charge of a sex offense?	☐	☐
c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving)	☐	☐
6. Have you ever been found in any civil, administrative or criminal proceedings to have:		
a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself?	☐	☐
b. committed any act involving moral turpitude, dishonesty or corruption?	☐	☐
c. violated any state or federal law or rule regulating the practice of a health care professional?	☐	☐
7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements.	☐	☐
8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority?	☐	☐
9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession?	☐	☐

4. AIDS Education and Training Attestation

I certify I have completed the minimum of seven (7) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS	DATE

5. Education

List in chronological order 30 hours of pharmacology education attended by you during the past two years. Include pharmacokinetic principles and their clinical application and use of pharmacological agents in the prevention of illness, restorations, maintenance of health. *Note: This may have been included in your NP Program. **This section only needs to be filled out if applying for Prescriptive Authority. Send in documentation of pharmacology (certificates, transcripts, etc.).**

PHARMACOKINETIC PRINCIPLES AND THEIR CLINICAL APPLICATIONS	CONTACT HOURS

6. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Washington State Nursing Commission
P.O. Box 1099
Olympia, WA 98507-1099

Sample
Joint Practice Agreement For Prescribing Schedule II-IV Medications

This Joint Practice Agreement (the "Agreement") is entered into this _____ day of the month of _____ in the year 2_____ by and between _____, Advanced Registered Nurse Practitioner (hereinafter the "ARNP") and _____ MD/DO.

WHEREAS, the ARNP and MD/DO desire to enter into a Joint Practice Agreement for purposes of implementing RCW 18.79.050 completing ARNP authority to prescribe and dispense Schedule II-IV Medications.

The parties shall agree as follows:

1. The ARNP may prescribe and dispense Schedule II-IV medications as permitted under RCW 18.79.050 and may collaborate with a Washington MD/DO in connection with the prescription of Schedule II-IV medications.
2. This agreement does not serve as a substitute for the independent clinical judgment of the ARNP based on the specific needs of the patient and this agreement does not place increased liability on the MD/DO for those decisions made by the ARNP.
3. Either party can revoke this agreement at any time with written notification to the Nursing Care Quality Assurance Commission.
4. Description of when the ARNP will collaborate with the MD/DO.

_____

_____

_____

_____

_____

_____

_____

5. Description of how collaboration will occur? (Face-to-face, e-mail, telephone, etc.)

_____

_____

_____

_____

_____

_____

_____

6. Description of how collaboration will be documented?

_____

_____

_____

_____

_____

_____

NAME OF ARNP (PRINT LEGIBLY)

NAME OF MD/DO (PRINT LEGIBLY)

SIGNATURE OF ARNP

SIGNATURE OF MD/DO

ARNP License # AP _____ Washington:

ARNP Expiration date _____ MD/DO License # _____

RN Expiration date _____ MD/DO Expiration date _____

Primary physical address of ARNP practice:

Primary physical address of MD/DO practice:

Return form to:

Department of Health
Attn: ARNP Desk
PO Box 1099
Olympia, WA 98507-1099

(360) 236-4708

https://fortress.wa.gov/doh/hpqa1/hps6/Nursing/default.htm